Cartesian Reflections on the Ether Screen

By George A. Mashour, M.D., Ph.D.

As Bob Dylan once sang, the times they are a-changin'—with summer upon us, we find ourselves at the beginning of a new academic life cycle. Many of the young physicians who burst upon the scene but three years ago have now departed, while a new cadre of budding anesthesiologists has arrived to fill their clogs. More broadly speaking, the political change on the horizon brings into question the very structure of our health care system. In these times of change, gentle reader, one must always reexamine the fundamentals—and in anesthesiology there is nothing of more fundamental yet neglected importance than *the ether screen.*

The ether screen (**Figure 1**), in its most superficial manifestation, is a frame that allows one to mount a surgical drape, a task that may also be accomplished with the use of flanking IV poles. As Miguel Colon-Morales pointed out on the occasion of the 150th anniversary of ether anesthesia, the precise history of the ether screen is unknown. The frame and screen itself serve several basic purposes, such as providing a space for the observation of the patient, as well as separating the sterile surgical field from the dirty little hands of the anesthetist. Several utilitarian modifications of the ether screen have been proposed. Looking back to the early literature of the journal *Anesthesiology,* we find articles such as "Ether Screen with Chin Holder" (R.C. Thompson, 1964) or "Combination Ether-Screen and Arm Rest" (N.B. Cornfield, 1951). More recently, Dr. Colon-Morales proposed the application of a tray to the ether screen for induction drugs and intubation equipment.

Figure 1: The ether screen

These trivial and superficial functions of the ether screen are of no consequence to us beyond historical footnote—I feel more than a twinge of compunction for even having discussed them here in the heady pages of the *Bulletin*. Nonetheless, a consideration of the ether screen's manifest properties was necessary before exploring the depths to which we shall soon plunge, fearlessly and together. Indeed, the purpose of this treatise is to make the claim that *the*

ether screen symbolizes the most profound schism in Western thought and directs us to the philosophical core of our profession.

Our story begins with the philosopher, physicist, and mathematician René Descartes, who divided the world into two types of reality, the *res extensa* and the *res cogitans.* These Latin terms refer to "extended stuff" and "thinking stuff"—and since their separation, Western philosophy has yet to recover. This division, which evolved out of the famous Cartesian *cogito ergo sum* (I think, therefore I am), is the foundation of *dualism:* other related dualities include mind-brain, mind-body, and subject-object. But how, you ask of René, does the stuff of the body relate to the stuff of the mind? Descartes, although undoubtedly a smarty of the highest order, had a rather sketchy explanation of how these two distinct substances interacted, positing that the pineal gland (central and singular in the brain) was the point of connection. Although Nobel laureate Sir John Eccles and Austrian philosopher Karl Popper made an argument for a more modern dualism in "The Self and its Brain," most of us would dismiss the position in its strongest form.

A more subtle argument is *property dualism,* namely, that there is one underlying reality of the universe that manifests itself as two different properties. One might make this claim of the body. There is one neutral substance, which has two different manifestations: *body as object* and *body as subject.* The body as object reveals the Cartesian "extended" properties of moving limbs, expanding lungs, and beating heart. The body as subject reveals the Cartesian "thinking" properties of perceiving, feeling pain, or experiencing sadness. Philosophers have been trying to unify these Cartesian dualities of the body for hundreds of years. What they have unfortunately failed to notice since October 16, 1846, is that *successful dualism is the key to successful surgery.*

Why was surgery such a limited endeavor prior to the birth of anesthesiology? The answer is that there was no controlled way of sifting out the *res cogitans* from the *res extensa,* no way of quieting the *body as subject* in order to operate efficiently on the *body as object.* For surgery to be successful the body must be somehow rendered an *object*—a belly or bone that feels something is not the substrate upon which a surgeon can readily act. This is where we as anesthesiologists play a crucial role—by temporarily extinguishing the subjectivity of the patient (locally, regionally, or generally), we allow the body to be manipulated as a pure object. While we must also modulate the physiology that is altered when subjectivity is suppressed, it is suspending the "thinking stuff" of the patient that is our primary mission. Thus, in the intraoperative setting, the surgical domain is that of the *res extensa,* while the anesthetic domain is that of the *res cogitans:* the boundary that delineates these two domains is none other than *the ether screen.*

Think about *that* the next time the surgeons are handing you the drapes.

*[**Editors' Note**: In this article, Dr. Mashour mentioned the Thompson ether screen with chin holder. Dr. Caryl Guth, former CSA president, reports that Thompson was, in fact, Dick Thompson, a practicing anesthesiologist at Mills Hospital in San Mateo from 1951-1980. His inventive mind traversed the ether screen's onto the surgical side, and one of his creations was the well known Thompson surgical retractor system that was "instrumental" in relieving medical students, interns and even junior surgical residents of the cursed duty of providing the surgical retraction for their "superiors." Needless to state, these retractors and their clones now are found in almost every operating room in the world. They became even more attractive to American surgeons when they no longer could find surgical assistants whose services would be reimbursed by insurers. Dr. Guth also told us that Dr. Thompson manufactured and drove an electric car far before such vehicles were considered seriously by the major automobile manufacturers.]*

California and National News

Is Disruptive Behavior by Physicians Growing Worse? Whenever ACPE puts on a workshop about disruptive physician behavior at one of our Institutes, the room is packed. Whenever we publish an article about disruptive behavior, it draws many readers.

Why is this happening? Is disruptive behavior by physicians growing worse? Not exactly, says behavior expert and ACPE faculty member Gerald Hickson, MD, of Vanderbilt University Medical Center. "I don't personally believe there are more incidents of disruptive behavior. But we're seeing less tolerance of the behaviors."

Hickson says nurses, orderlies, surgical assistants and other members of a health care organization's medical team are fed up with bullish behavior by physicians, and they're much more willing to report it.

One of the reasons may be generational. Younger medical workers are more willing to challenge authority figures if they feel they've been wronged. "There's a clear recognition that even though physicians have special skills, those skills should not exempt them from appropriate professional behaviors," Hickson says.

Perhaps even more significant, the exploding emphasis on patient safety encourages medical workers to be more vigilant about all work-related behaviors. "People aren't willing to tolerate it because there's growing evidence of the threat to patient safety associated with non-professional conduct," Hickson says. "Teams are essential in health care, and behavior can negatively affect clear communication and teamwork."

Finally, competition in the marketplace may actually be helping to rout out disruptive docs. "In the competitive medical marketplace we need to be sure our patients are satisfied and that we meet or exceed their expectations. If patients are affected by unprofessional conduct they're likely to go elsewhere, fail to follow medical recommendations, or even file a lawsuit," Hickson adds. (From ACPE.)